FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0018150

Facility Name: McLean County Nursing Home

Address: 901 North Main Street (Number) Normal (City) 61761 (Zip Code)

County: McLean

Telephone Number: (309) 888-5380 Fax # (309) 454-4594

IDPA ID Number:

Date of Initial License for Current Owners: 01-Oct-71

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	x	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	x	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Donald Lee Telephone Number: (309) 888-5380

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Donald Lee
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,552	1,497	2,354	5,403	8
9	SNF/PED					9
10	ICF	29,090	15,533		44,623	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,642	17,030	2,354	50,026	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.12%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES [ ] NO [X]

I. On what date did you start providing long term care at this location? Date started 01-Oct-71

J. Was the facility purchased or leased after January 1, 1978? YES [ ] Date 01-Oct-71 NO [X]

K. Was the facility certified for Medicare during the reporting year? YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 2,354

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [x] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number: McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	308,165	26,904	10,098	345,167		345,167		345,167			1
2	Food Purchase		297,470		297,470		297,470	(30,088)	267,382			2
3	Housekeeping	173,480	35,586		209,066		209,066		209,066			3
4	Laundry	109,898	31,656		141,554		141,554	(6,455)	135,099			4
5	Heat and Other Utilities			228,730	228,730		228,730		228,730			5
6	Maintenance	115,149	40,250	17,282	172,681		172,681	4,778	177,459			6
7	Other (specify):*											7
8	TOTAL General Services	706,692	431,866	256,110	1,394,668		1,394,668	(31,765)	1,362,903			8
	B. Health Care and Programs											
9	Medical Director			75	75		75		75			9
10	Nursing and Medical Records	2,212,211	12,059	145,660	2,369,930		2,369,930		2,369,930			10
10a	Therapy			138,950	138,950		138,950		138,950			10a
11	Activities	86,460	2,799	1,538	90,797		90,797		90,797			11
12	Social Services	88,945	278	1,538	90,761		90,761		90,761			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,387,616	15,136	287,761	2,690,513		2,690,513		2,690,513			16
	C. General Administration											
17	Administrative	93,661		62,303	155,964		155,964	(8,901)	147,063			17
18	Directors Fees							45,121	45,121			18
19	Professional Services			7,531	7,531		7,531	173,127	180,658			19
20	Dues, Fees, Subscriptions & Promotions			15,061	15,061	896	15,957	(896)	15,061			20
21	Clerical & General Office Expenses	128,103	18,936	42,919	189,958	(1,050)	188,908	(12,870)	176,038			21
22	Employee Benefits & Payroll Taxes			858,053	858,053		858,053		858,053			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,238	2,238	154	2,392		2,392			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			105,414	105,414		105,414		105,414			26
27	Other (specify):*											27
28	TOTAL General Administration	221,764	18,936	1,093,519	1,334,219		1,334,219	195,581	1,529,800			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,316,072	465,938	1,637,390	5,419,400		5,419,400	163,816	5,583,216			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassificatio

Facility Name & ID Number McLean County Nursing Home #0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			166,014	166,014		166,014	4,885	170,899			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			166,014	166,014		166,014	4,885	170,899			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		131,274		131,274		131,274		131,274			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,350	82,350		82,350		82,350			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		131,274	82,350	213,624		213,624		213,624			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,316,072	597,212	1,885,754	5,799,038		5,799,038	168,701	5,967,739			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(629)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,162	30.3		9
10	Interest and Other Investment Income		32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional		20.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	(46,957)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (45,424)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	214,125		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 214,125		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 168,701		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Lawn Service	$	City of Normal		$ 4,778	$ 4,778	1
2	V	18	County Board		McLean County	100.00%	45,121	45,121	2
3	V	19	Information Services		McLean County	100.00%	7,730	7,730	3
4	V	17	County Administrator	62,303	McLean County	100.00%	53,402	(8,901)	4
5	V	19	County Auditor		McLean County	100.00%	55,256	55,256	5
6	V	19	County Treasurer		McLean County	100.00%	110,141	110,141	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 62,303			$ 276,428	$ * 214,125	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: McLean County Government
Street Address: 104 West Front Street
City / State / Zip Code: Bloomington, IL 61702
Phone Number: (309) 888-5110
Fax Number: (309) 888-5111

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	County Board	Expenditures	100,000	20 Funds	$ 227,438	$ 104,222	19,839	$ 45,121	1
2	19	Information Services	% of Effort	100,000	20 Funds	1,658,787	742,810	466	7,730	2
3	17	County Administrator	FTE	100,000	20 Funds	516,664	261,182	10,336	53,402	3
4	19	County Auditor	Transactions	100,000	20 Funds	480,741	218,860	11,494	55,256	4
5	19	County Treasurer	Warrants	100,000	20 Funds	679,421	213,105	16,211	110,141	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,563,051	$ 1,540,179		$ 271,650	25

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Relatec											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

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13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME McLean County Nursing Home COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0018150

CONTACT PERSON REGARDING THIS REPORT Donald Lee

TELEPHONE (309) 888-5380 FAX #: (309) 454-4594

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION

A. Square Feet: 58,065 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc. List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 15,000	1
2					2
3	TOTALS			$ 15,000	3

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		Jan-74	Jan-74	$ 2,907,918	$ 72,695	40	$ 72,698	$ 3	$ 2,199,391	4
5			Jan-75	Jan-75	66,046	1,652	40	1,651	(1)	48,843	5
6			Jan-76	Jan-76	32,940	825	40	824	(1)	23,553	6
7											7
8											8
	Improvement Type**										
9	Paging System			Dec-89	2,588	129	20	129		1,936	9
10	Smoke Detectors			Dec-89	2,418		5			2,418	10
11	Air Cond & Boiler			Nov-79	40,718		40	1,018	1,018	29,195	11
12	Roof Repairs			Jun-82	3,374		40	84	84	1,848	12
13	Smoke Damper			Jul-83	3,600		40	90	90	1,980	13
14	Various - 1984			May-84	58,471	539	20	535	(4)	58,471	14
15	Fan Coil Units			Apr-84	1,158		15			1,158	15
16	Temp Sensors			Feb-85	499		10			499	16
17	Wood shed			Jul-85	749		15			749	17
18	Sewer Machine & 100 Gal Tank			Apr-86	1,592	60	20	80	20	1,457	18
19	Rear Door - Vestibule			Jan-84	1,962	49	40	49		1,029	19
20	Various - 1987			May-87	19,471	728	20	974	246	17,001	20
21	Concrete & Asphalt			Jun-87	19,249		10			19,249	21
22	Fire Doors			Jun-88	1,070	54	20	54		917	22
23	Replace Roof			Aug-88	481,262	26,515	18	26,737	222	427,792	23
24	Boiler Repairs			Dec-89	917		10			917	24
25	Masonry Repars - Bldg			Oct-89	5,521	221	25	221		3,314	25
26	Telephone System			Jan-88	4,250	170	25	170		2,890	26
27	Courtyard Repairs			May-89	2,191	83	20	110	27	1,650	27
28	Fire Alarm Control Panel			Nov-89	5,072		10			5,072	28
29	Capital Improvements			Jul-90	21,349	644	15	1,423	779	21,345	29
30	Capital Improvements			Mar-91	2,390	120	20	120		1,680	30
31	Heat Exchanger			Mar-91	2,236		10			2,236	31
32	Door Frame & Dining Room Remodel			May-92	6,350	173	40	159	(14)	1,952	32
33	Direct Cable - 500 Ft.			Feb-92	168	7	23	7		91	33
34	Closure & Power Frame Assembly			May-92	2,545		10			2,545	34
35	Boilers (2) & Stacks			Oct-92	63,200	3,160	20	3,160		37,920	35
36	Toilet Rails & Water Booster			Jun-93	2,585	172	15	172		1,979	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Storage Tank	Nov-93	$ 10,558	$ 211	50	$ 211	$	$ 2,352	37
38	Stairsteps	Nov-93	289	10	30	10		111	38
39	Air Cond & Boiler	Nov-80	9,889		20	494	494	5,928	39
40	Remodel Nurses Station	Apr-94	2,283	152	15	152		1,629	40
41	Air Cond Units (2)	Jul-94	79,305	5,287	15	5,287		55,260	41
42	IDPA Audit	Jan-92	4,243		10			4,243	42
43	Kitchen Walk-in Freezer/Cooler	Oct-96	11,038	552	20	552		4,510	43
44	Closed Circuit TV System-Recorder	Feb-98	3,208		5			3,208	44
45	NT System Wiring & Switches	Dec-98	4,222		5			4,222	45
46	Bathroom Improvements	Aug-99	9,505	951	10	951		5,141	46
47	Four Water Coolers	Jul-99	2,089	209	10	209		1,139	47
48	Aluminum Cubicle Track	Sep-99	7,578	379	20	379		2,011	48
49	Roofing Repairs	May-99	29,217	1,461	20	1,461		8,206	49
50	Cooridor Fire Doors	Dec-99	4,495	225	20	225		1,137	50
51	Time Clock System	Jul-99	7,144	476	15	476		2,603	51
52	Lamp Fixture Improvement	Aug-00	1,218	122	10	122		539	52
53	Room Remodeling Project 2000	Dec-00	39,599	2,700	15	2,640	(60)	10,560	53
54	Kitchen Disposal Unit	Jun-00	1,789	224	8	224		1,018	54
55	Room Remodeling Project 2000	Jan-01	40,993	2,956	15	2,733	(223)	10,924	55
56	Life Safety Project	Oct-01	12,937	866	15	862	(4)	2,690	56
57	Door Lock Project	Mar-01	31,078	2,072	15	2,072		7,794	57
58	Room Remodeling Project 2000	Jan-02	37,526	2,397	15	2,502	105	7,499	58
59	Kitchen Flooring	Sep-02	16,548	1,655	10	1,655		3,786	59
60	Generator Project	May-02	47,920	3,195	15	3,195		8,281	60
61	Administration Remodel	Sep-02	17,510	1,174	15	1,167	(7)	2,549	61
62	Paging System	Sep-02	3,217	210	15	214	4	493	62
63	Nurse's Station	May-03	1,403	94	15	94		153	63
64	Phase II Remodel - 300 Wing	Nov-03	13,354	890	15	890		995	64
65	Parking Lot Repaving	Sep-04	64,698	1,078	15	1,123	45	1,123	65
66	Remodel 300 Wing	Jan-04	6,770	414	15	418	4	418	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,285,483	$ 137,956		$ 140,783	$ 2,827	$ 3,081,599	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 731,373	$ 25,164	$ 25,164	$	various	$ 535,617	71
72	Current Year Purchases	49,892	2,229	2,229		various	2,229	72
73	Fully Depreciated Assets	162,599				various	162,599	73
74								74
75	TOTALS	$ 943,864	$ 27,393	$ 27,393	$		$ 700,445	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	Pick-up, '96 Dodge 4 x 4	Jan-96	$ 19,549	$ 226	$	$ (226)	5	$ 19,549	76
77	Patient Transport	Bus, '81 Ford	Oct-82	26,620				15	26,620	77
78	Maintenance	Tractor, Sears	Sep-96	3,509	439		(439)	5	3,509	78
79										79
80	TOTALS			$ 49,678	$ 665	$	$ (665)		$ 49,678	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,294,025	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 166,014	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 168,176	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,162	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,831,722	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 8,603	92
93			93
94			94
95		$ 8,603	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	137	$ 8,882	$	137	$ 8,882	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		199	5,119		199	5,119	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		253	16,441		253	16,441	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				68,315		68,315	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39.2								12
13	Other (specify): Medical Supplies	39.2					62,960		62,960	13
14	TOTAL			$	589	$ 30,442	$ 131,274	589	$ 161,717	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number: McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,701,584	$	1
2	Cash-Patient Deposits	18,825		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	616,847		3
4	Supply Inventory (priced at FIFO)	40,103		4
5	Short-Term Investments	1,400,000		5
6	Prepaid Insurance	19,262		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	7,314		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 4,803,935	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	4,233,121		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	827,604		16
17	Accumulated Depreciation (book methods)	(3,585,996)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	8,603		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 1,498,332	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 6,302,267	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (474,792)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(18,825)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	(212,612)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ (706,229)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ (706,229)	$	46
47	TOTAL EQUITY(page 18, line 24)	$ (5,596,038)	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ (6,302,267)	$	48

*(See instructions.)

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reportec	$ 5,422,883	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(2,380)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 5,420,503	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	175,535	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	$ 175,535	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	$ 5,596,038	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All require classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,419,945	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 5,419,945	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	29,459	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	6,455	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 35,914	23
	D. Non-Operating Revenue		
24	Contributions	465,306	24
25	Interest and Other Investment Income***	40,588	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 505,894	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	12,820	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 12,820	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 5,974,573	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,394,668	31
32	Health Care	2,690,513	32
33	General Administration	1,334,219	33
	B. Capital Expense		
34	Ownership	166,014	34
	C. Ancillary Expense		
35	Special Cost Centers	131,274	35
36	Provider Participation Fee	82,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 5,799,038	40
41	Income before Income Taxes (line 30 minus line 40)**	175,535	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ 175,535	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,936	2,120	$ 57,987	$ 27.35	1
2	Assistant Director of Nursing	3,904	4,343	81,663	18.80	2
3	Registered Nurses	14,692	16,450	361,226	21.96	3
4	Licensed Practical Nurses	18,637	20,460	369,099	18.04	4
5	Nurse Aides & Orderlies	115,561	126,564	1,305,537	10.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,608	2,169	29,372	13.54	9
10	Activity Assistants	5,955	6,569	57,088	8.69	10
11	Social Service Workers	6,738	7,584	88,945	11.73	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,137	37,296	17.45	13
14	Head Cook	1,904	2,104	27,170	12.91	14
15	Cook Helpers/Assistants	27,983	30,310	243,699	8.04	15
16	Dishwashers					16
17	Maintenance Workers	6,821	7,426	115,149	15.51	17
18	Housekeepers	18,161	19,695	173,480	8.81	18
19	Laundry	11,288	12,313	109,898	8.93	19
20	Administrator	1,968	2,235	93,661	41.91	20
21	Assistant Administrator	1,852	2,123	39,862	18.78	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,704	6,503	88,241	13.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	2,923	3,563	36,699	10.30	33
34	TOTAL (lines 1 - 33)	249,571	274,668	$ 3,316,072 *	$ 12.07	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	291	$ 10,098	1.3	35
36	Medical Director		75	9.3	36
37	Medical Records Consultant	20	1,200	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,538	11.3	44
45	Social Service Consultant	30	1,538	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	370	$ 14,448		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	6,070	144,168	10.3	52
53	TOTAL (lines 50 - 52)	6,070	$ 144,168		53

Facility Name & ID Number: McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Donald Lee	Administrator	-0-	$ 93,661
TOTAL (agree to Schedule V, line 17, col. 1)			$ 93,661
(List each licensed administrator separately.)			

B. Administrative - Other

Description	Amount
County Administration Fee	$ 62,303
TOTAL (agree to Schedule V, line 17, col. 3)	$ 62,303
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Robert Rein, CPA	Consulting	$ 7,531
TOTAL (agree to Schedule V, line 19, column 3)		$ 7,531
(If total legal fees exceed $2500 attach copy of invoices.)		

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,960
Unemployment Compensation Insurance	
FICA Taxes	252,396
Employee Health Insurance	358,680
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	209,175
Employee Physicals	2,842
TOTAL (agree to Schedule V, line 22, col.8)	$ 858,053

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,427
Health Care Worker Background Check	
(Indicate # of checks performed 66)	
Life Services Network of Illinois	6,973
Nursing Books & Subscriptions	147
Other Dues	204
County Nursing Home Association	1,310
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,061

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	426
Seminar Expense	1,966
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,392

**See instructions.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of Illinois 6,973

(3) Did the nursing home make political contributions or payments to a politica
action organization? No If YES, have these costs
been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6.31

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ 1,254 Line 10.2

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. No

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO x If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
of Public Aid during this cost report period. $ 82,350
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? Yes If YES, attach an explanation of the allocation.
Laundry & Housekeeping split on time spent.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? No For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit
on Schedule V. $ Has any meal income been offset against
related costs? Yes Indicate the amount. $ 629

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? No If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjustec
out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: County Auditor The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? No If no, please explain. Audit report not complete.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service
performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.